EXHIBIT Z

D K								
DATE OF VISIT	AGE	DOCTOR NAME	WEIGHT	WT%	HEIGHT	HT%	BMI	BMI%
9/27/12	Birth	Banner	2.7 kg					
3/5/15	2.5	Dr. Jafri	33.2 lb	86th	35 in	35th	19.01	
9/29/15	3	Dr. Jafri	36.6 lb	89th	37 in	40th	18.68	
11/20/15	3.1	Dr. Jafri	36.2 lb	86th	37.5 in	46th	18.06	
4/10/17	4.6	Dr. Jafri	35.6 lb		39 in		16.35	
5/10/17	4.8	Dr. Jensen	37 lb		39.1 in		17	50.9
11/15/17	5.1	Dr. Jensen	41.8 lb		41 in		17.5	59.1
1/8/18	5.3	Dr. Jensen	41.2 lb (18.688 kg)		40.5 in		17.7	62
9/4/18	5.11	Ruiz, FNCP	43.4 lb	37th	39 in	0.9th	19.99	
9/19/18	5.11	Ruiz, FNCP	43.4 lb	37th	39 in	0.9th	19.99	
9/20/18	5.11	Dr. Jensen	42.8 lb		42.5 in		16.7	44
10/18/18	6	Dr. Jensen						
11/8/18	6.1	PCH	92.6 lb (42 kg)					
11/8/18	6.1		38 lb					
12/24/18	6.1	Dr. Miga	40.34 lb (18.3 kg)					
1/3/19	6.3		40.34 lb (18.3 kg)		105 cm		16.6	
10/26/22	10	Dr. Jensen	86 lb		55 in		20	85.7

Mistake in PCH records?

EXHIBIT 17
Bell 8/12/24

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

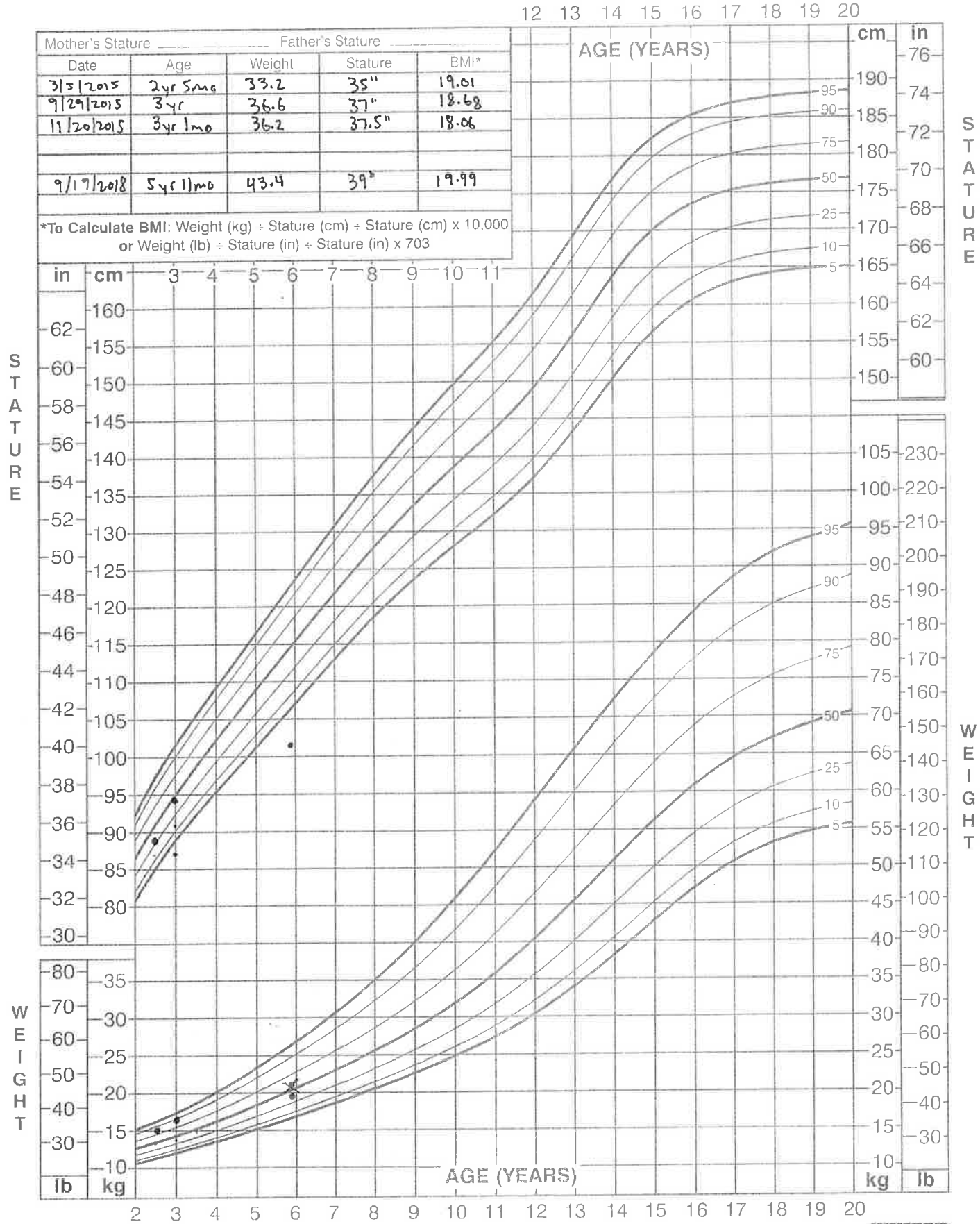
NAME D

RECORD #

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*
3/5/2015	2yr 5mo	33.2	35"	19.01
9/29/2015	3yr	36.6	37"	18.68
11/20/2015	3yr 1mo	36.2	37.5"	18.06
9/17/2018	5yr 11mo	43.4	39"	19.99

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000 or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00)
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
SAFER · HEALTHIER · PEOPLE

Patient: K , C
Account Number:
DOB: (**Age:** 2Y 5M **Sex:** Male
Phone:
Address: 1

Provider: Asma Jafri, MD
Date: 03/05/2015

Subjective:

Chief Complaints:
1. NP 2yr wcc + Autism, here w/ parents...MN.

HPI:
Well Baby/Toddler Visit:
Nutrition Gluten free, dairy free and dye free diet. Eats fruits vegetables and meats.. Sleep no concerns voiced, napping 1-2 times per day, all night, own bed. elimination starting to potty train, stooling and voiding normally. Immunization Reactions none. Child Care at home with family. Lead Risk no obvious risk factors. Social Development parallel play. Language 2 words sentences, follows 2 step commands, listens to stories being read. Gross Motor Development walks up/down steps. Fine Motor removes shoes, pants,imitates stroke with pencil, . Growth-development removes some clothes, follows commands. Cognitive Development listens to stories. Health no recent illness, discussed immunizations. Household Hazards discussed poisionings and ingestions, reviewed calling poison control center, keep medications and cleaning supplies out of reach, reviewed hazards in kitchen, discussed keeping water heater at 120 degrees. Sibling Relations reviewed, sibling(s) coping well. Supplement multivitamin. Car Seat uses all the time, forward facing. Hearing normal.
ADD/ADHD/Behavioral problems:
Was dx with autism spectrum d/o June of 2014, getting ST,OT and habilitation therapies, doing very well on current therapies.

ROS:
General:
sleep normal. appetite normal. elimination normal.

Hospitalization/Major Diagnostic Procedure: Denies Past Hospitalization.

Family History: Non-Contributory

Social History: Parents: married. no Day Care. no Guns in Home. no Family Smoking. no Pets at Home.

Medications: None

Allergies: N.K.D.A.

Objective:

Vitals: Ht 35 in, Ht %ile 35%, Wt 33 lb 2 oz, Wt %ile 86%, HC 19, Temp 98.8 F, BP unable, BMI 19.01.

Examination:
General Pediatric Exam:
General appearance: well nourished, no obvious distress, alert,active, well hydrated. Skin: normal, moist, warm. Head: normocephalic. Eyes: red reflex present bilaterally, PERRL, no eye discharge. Ears: TM's normal bilaterally. Nose: nares patent and clear, mucosa normal. Oral cavity/Throat: moist mucus membranes, tonsils normal. Neck: supple, no lymphadenopathy. Chest: symmetric. Heart: RSR, no murmurs. Lungs: clear, equal breath sounds bilaterally. Abdomen: soft,nontender, no masses, normal bowel sounds, no organomegaly. Genitalia: normal external genitalia. Extremities/back: no cyanosis, clubbing, or edema. Neurologic exam: normal tone and motor development, normal sensory system and reflexes, normal cranial nerves II-XII.

Assessment:

Assessment:
1. Well baby/ child exam - V20.2 (Primary)
2. Autistic disorder NOS - 299.00

Plan:

1. Well baby/ child exam
Notes: age appropriate anticipatory guidance provided.

2. Autistic disorder NOS
Notes: Doing very well on the current therapy, will continue those, also seeing Dr Jissan every year.

Preventive:

Infant: Discussed growth . Discussed development . Immunization risks and benefits need for Hep A vaccine. handout given. Lead risk assessed . Vitamins/Nutrition . Dental/tooth brushing . Potty training .

Terrible two's.

Follow Up: well child in 1 year, flu shot in the winter

Provider: Asma Jafri, MD
Patient: K D **DOB:** C **Date:** 03/05/2015

Electronically signed by Isabel Cervantes on 05/12/2015 at 12:19 PM MST
Sign off status: Completed

Progress Notes

Patient: K , D
Account Number:
DOB: (**Age:** 3Y **Sex:** Male
Phone:
Address: esa, AZ-85202

Provider: Asma Jafri, MD
Date: 09/29/2015

Subjective:

Chief Complaints:
1. 3yr wcc, here w/parents...tr.

HPI:
Well Baby/Toddler Visit:
Nutrition good appetite, on gluten diet, eating fruits and vegetables, eating meats, other proteins. Sleep normal for age. elimination stooling and voiding normally, potty trained. Immunization Reactions no problems with previous immunizations. Child Care at home with family. Social Development plays cooperatively. Language sings a song, speech intelligible, knows first and last name. Gross Motor Development rides tricycle. Fine Motor draws a person, . Growth-development Hops on one foot, dresses self. Cognitive Development knows first and last name. Health no recent illness. Household Hazards reviewed. Sibling Relations no issues. Car Seat forward facing, uses all the time. Hearing normal.
ADD/ADHD/Behavioral problems:
Getting habilitation and OT therapy.

ROS:
General:
sleep normal, normal. appetite normal, normal. nutrition Good eater. elimination normal, normal.

Hospitalization/Major Diagnostic Procedure: Denies Past Hospitalization.
Social History: Parents: married. no Day Care. no Guns in Home. no Family Smoking. no Pets at Home.
Medications: None
Allergies: N.K.D.A.

Objective:

Vitals: Ht 37 in, Ht %ile 40%, Wt 36 lb 6 oz, Wt %ile 89%, Temp 98.6t, BP 92/42, BMI 18.68.

Examination:
Preschool:
General Appearance: alert, well hydrated, no acute distress. Head: atraumatic. Eyes: red reflex present, PERRLA, EOMI, sclera clear. Ears: canals normal, TM's gray with good movement. Nose: moist membranes, , clear rhinorrhea. Mouth/Throat: moist mucous membrances, tonsils without erythema or exudate. Neck: supple, FROM, no cervical adenopathy. Heart: regular rate and rhythm, no murmurs. Lungs: clear to auscultation. Abdomen: soft, nontender, bowel sounds present, no masses, no organomegaly. Genitalia: normal external genitalia. Extremities/Back: upper extremities normal, lower extremities normal. Skin: no rashes. Neuro: cranial nerves II-XII grossly intact, strength and sensory exam within normal limits, normal gait.

Assessment:

Assessment:
1. *Well infant/child exam - V20.2 (Primary)

Plan:

1. *Well infant/child exam
Notes: age appropriate anticipatory guidance provided.

Preventive:

Child: Growth discussed . Development discussed . Nutrition/Vitamins . Dental care . School readiness . Reading .. Seat belt carseat. Gun safety . Immunization risk and benefit Discussed need for Measles,Mumps, Rubella, Varicella,Diphtheria,Tetanus,Acellular Pertusis,and Polio vaccines. Risks discussed. Handout given.. Lead risk assessed .

Follow Up: 1 Year for next physical, flu shot in the winter

Provider: Asma Jafri, MD
Patient: K , D **DOB:** (**Date:** 09/29/2015

Electronically signed by Isabel Cervantes on 05/02/2016 at 10:35 AM MST
Sign off status: Completed

progress note

Patient: K , D
Account Number:
DOB: **Age:** 3Y 1M **Sex:** Male
Phone:
Address: , Mesa, AZ-85202

Provider: Asma Jafri, MD
Date: 11/20/2015

Subjective:

Chief Complaints:
1. croupy cough/LM RN, here w/mom...tr.

HPI:
ENT/respiratory:
Dylan started with a croupy cough since last night. Mom started the humidifier in his room. He also has a runny nose. He is eating ok. Has been running a fever. Mom had to take him to the ER last time when he had croup. He had no respiratory distress, but was coughing a lot last night and was restless.

Hospitalization/Major Diagnostic Procedure: Denies Past Hospitalization.

Social History: Parents: married. no Day Care. no Guns in Home. no Family Smoking. no Pets at Home.

Medications: None

Allergies: N.K.D.A.

Objective:

Vitals: Ht 37.5 in, Ht %ile 46%, Wt 36 lb 2 oz, Wt %ile 86%, Temp 99.6t, BP 88/50, BMI 18.06.

Examination:
ENT/Respiratory:
General appearance: pleasant, NAD, well nourished and hydrated, cooperative. bilaterally, tympanic membranes with good light reflex and gray color. Nose: clear rhinorrhea. Oral Cavity: no erythema no exudate seen on pharynx. Neck: no cervical lymphadenopathy. Heart: regular rate and rhythm, normal S1, S2. No murmur. Lungs: clear to auscultation bilaterally, no crackles or wheezes, no stridors . Abdomen: soft, nondistended, nontender, BS present, no masses felt, no hepatosplenomegaly.

Assessment:

Assessment:
1. Fever, unspecified - R50.9 (Primary)
2. Acute obstructive laryngitis [croup] - J05.0

Plan:

1. Fever, unspecified
Notes: Mom can give him Tylenol or Motrin on PRN basis for fever above 100.4oF. Also she can give him as a pain reducer on PRN basis.

2. Acute obstructive laryngitis [croup]
Notes: Will give him Decadron 4 mg/1 ml, 3 ml po x 1 in the office. Teaching done in detail, reassured mom that he is in no respiratory distress, his RR 28 BPM, he does have a cough during exam, but no stridors or wheezes. Usually viral illness takes 5-7 days to resolve. Advised mom to continue with humidifier. Also told her to take him to ER if he has s/s of respirator distress. Mom understands and agrees with the above plan.

Procedure Codes: J1100 *Decadron Injectable 4mg/ml, 90473 Admin for oral/nasal

Follow Up: prn

Electronically signed by Isabel Cervantes on 05/02/2016 at 10:46 AM MST
Sign off status: Completed

progress note

Patient: Ka , [
Account Number:
DOB: (**Sex:** Male
Phone: 4
Address: Mesa, AZ-85202

Provider: Asma Jafri, MD
Date: 04/10/2017

Subjective:

Chief Complaints:
1. Injured rt arm and wrist yesterday with golf club, has weekness and c/o pain when putting pressure on it, here w/mom...tr.

HPI:
Wrist / hand:
He was at Golf land with his family, he was holding golf club and he accidentally tripped and fell on the astroturf, injuring his right hand /wrist. Mom states that there was no swelling or bruising. Mom gave some herbal pain medication last night. He does complain at times when he put pressure on that hand. But there is no redness, swelling or any deformity.

Hospitalization/Major Diagnostic Procedure: Denies Past Hospitalization.

Social History: Parents: married. no Day Care. no Guns in Home. no Family Smoking. no Pets at Home.

Medications: None

Allergies: N.K.D.A.

Objective:

Vitals: Ht 39 in, Wt 35 lb 6 oz, Temp 98.9t, BP 82/42, BMI 16.35.

Examination:
Wrist / hand:
Wrist/hand: right. Inspection: no swelling, redness or eccymosis, no tenderness. Range of motion: normal flexion and extension, normal ulnar and radial deviation. Palpation: nontender. Motor system: normal grip strength. Sensory system: normal touch and pain sensations. Fist: normal strength.
Brief Normal Exam:
General appearance: NAD, well nourished and hydrated. HEENT: TMs pearly bilaterally, pharynx and tonsils normal. Heart: regular rate and rhythm, no murmurs. Lungs: clear to auscultation.

Assessment:

Assessment:
1. Unspecified injury of right wrist, hand and finger(s), initial encounter - S69.91XA (Primary)

Plan:

1. Unspecified injury of right wrist, hand and finger(s), initial encounter
Notes: He has a normal exam today, there is no deformity or any swelling, tenderness or bruising seen. He has full range of motion. Advised mom to watch his symptoms at this time. We will get an Xray of the right hand and wrist in case his symptoms of pain/swelling increase in the next 72 hrs. Xray order slip was given to mom.

Follow Up: prn

Provider: Asma Jafri, MD
Patient: Kahraman, Dylan **DOB:** 09/27/2012 **Date:** 04/10/2017

Electronically signed by Isabel Cervantes MA on 09/15/2017 at 03:26 PM MST
Sign off status: Completed

SimonMed
See Tomorrow Today

FINAL

SimonMed Mesa Desert Campus
DIAGNOSTIC IMAGING REPORT

Patient: Ka , D Sex: M DOB: Age: Diag. Imaging # 2790554
Status: Outpatient Stat (PEDS)
Referring Physician: Jafri Asma

Exam # 21825404 - **Apr 13, 2017** - X-Ray - WRIST 3 VIEWS (Right)

Exam Performed at SimonMed Mesa Desert Campus

CLINICAL HISTORY: Fell 4 days ago, having persistent right-sided hand and wrist pain.

TECHNIQUE: AP, lateral and oblique views of the right wrist were obtained.

FINDINGS: No fracture, subluxation or dislocation is appreciated. No joint space abnormality or osseous lesion is identified. No significant soft tissue swelling is appreciated.

IMPRESSION:

Normal right wrist.

Lance A. Cohen, M.D., DABR
CAQ in Pediatric Imaging

ELECTRONICALLY SIGNED BY: Cohen MD, Lance on Apr 13, 2017

dd: April 13, 2017

Reported by: Lance Cohen MD
Electronically signed by: Lance Cohen MD

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.

progress note

Patient: K , D
Account Number: 92063
DOB: 0 **Sex:** Male
Phone:
Address a, AZ-85202

Provider: Jessica L. Ruiz FNPC
Date: 09/04/2018

Subjective:

Chief Complaints:
1. right knee injury on july 2nd here with mom ... MR.

HPI:
Knee / shin:
Per mom patient twisted his ankle and his right knee on July 2nd. He fell to the ground and was crying. He was unable to walk for about a week. Did see the chiropractor the next day who didn't feel like he torn anything and just needed to rest it. He seemed to get back to normal but is now having some trouble. Mom thinks he may have reinjured it when bowling. This past Friday he was sitting on the floor and had difficulty standing. He did have some buckling over the weekend. Seems to be a little better today.

ROS:
Musculoskeletal:
joint pain yes, right knee pain..

Medical History:

Social History: Parents: married. no Day Care. no Guns in Home. no Family Smoking. no Pets at Home.

Allergies: N.K.D.A.

Objective:

Vitals: Ht 39 in, Wt 43 lb 4 oz, Temp 98.4t, BP 84/42, BMI 19.99, HR 92.

Examination:
Brief Normal Exam:
General appearance: NAD, well nourished and hydrated. HEENT: TMs pearly bilaterally, pharynx and tonsils normal. Heart: regular rate and rhythm, no murmurs. Lungs: clear to auscultation.
Knee / shin:
Knee: right. Inspection: no swelling or redness,no ecchymosis. Palpation: no tenderness on jointlines or collateral ligaments. Collateral ligaments: intact medially and laterally. Range of motion: normal flexion and extension.

Assessment:

Assessment:
1. Pain in right knee - M25.561 (Primary)

Plan:

1. Pain in right knee
Notes: Will refer to ortho due to length of pain. Rest, ice, ibuprofen as needed.
Referral To:Orthopedic Surgery
Reason:Pain in right knee - mom prefers Banner.

Follow Up: 1 Week for wcc.

Provider: Jessica L. Ruiz FNPC
Patient: Kahraman, Dylan **DOB:** 09/27/2012 **Date:** 09/04/2018

Electronically signed by Isabel Cervantes MA on 01/25/2019 at 12:01 PM MST

Progress Notes

Patient: K , D
Account Number: 92063
DOB: (
Phone
Address: 1 sa, AZ-85202

Sex: Male

Provider: Jessica L. Ruiz FNPC
Date: 09/19/2018

Subjective:

Chief Complaints:
1. 5 yr wcc/ref to Opthalmology.

HPI:

Well Baby/Toddler Visit:

Nutrition good appetite, usually well-balanced, eating fruits and vegetables, eating meats, other proteins. Sleep normal for age. elimination stooling and voiding normally. Immunization Reactions none. Child Care Just started kindergarten and is doing well. Is in a self contained room.. Social Development plays make believe and dress-up. Language Will be getting ST at school. . Gross Motor Development skips, ties shoes, climbs ladder, is getting OT/PT at home. . Fine Motor draws a 4 part person, prints name, copies triangle or square, working on buttoning buttons ans zippers. Gets OT at home.. Cognitive Development knows full name, address and telephone number; can count on fingers. Health no recent illness. Household Hazards discussed poisionings and ingestions, reviewed calling poison control center, keep medications and cleaning supplies out of reach. Sibling Relations no issues. Car Seat forward facing, uses all the time, change to booster seat at 5 yrs and 50#. . Hearing normal.

Knee / shin:

Still having right knee pain. Did see ortho twice and they told them to give it 6-8 weeks. No imaging was done. They also went to a sports medicine PT. Will be doing PT. Is using a wheelchair at school. Is starting to walk a bit.

Ophthalmology:

Mom has noticed that he is starting to hold things close to him when reading.

ROS:

General:

sleep normal. appetite normal. energy level normal. nutrition Good eater. elimination normal.

Medical History:

Objective:

Vitals: Ht 39 in, Ht %ile 0.09%, Wt 43 lb 4 oz, Wt %ile 37%, Temp 98.3t, BP 84/46, BMI 19.99, HR 116.

Examination:

General Pediatric Exam:

General appearance: well nourished, alert,active. Skin: normal, no rashes, dry, warm, well-perfused without rashes. Head: normocephalic. Eyes: red reflex +, PERLA, fundi normal. Ears: bilateral TM normal color, canals normal. Nose: nares patent and clear, mucosa normal. Oral cavity/Throat: moist mucus membranes, no lesions. Neck: supple,no lymphadenopathy. Heart: RSR, normal S1S2, no murmurs. Lungs: clear, equal breath sounds bilaterally. Abdomen: soft,nontender, no masses, normal bowel sounds. Genitalia: normal external genitalia,normal uncircumcised male with testes down and normal,foreskin fully retractable. Extremities/back: good range of motion, no scoliosis. Neurologic exam: normal tone and motor development, normal sensory system and reflexes.

Assessment:

Assessment:
1. Encounter for routine child health examination without abnormal findings - Z00.129 (Primary)
2. Unspecified disorder of refraction - H52.7

Plan:

1. Encounter for routine child health examination without abnormal findings
Notes:

Follow up with PT and ortho as planned.

.

2. Unspecified disorder of refraction
Notes: Will refer back to AZ Pediatric Eye specialists for eye exam and check up.
Referral To:Ophthalmology
Reason:Saw AZ Pediatric Eye specialists in the past.

3. Others
Notes: age appropriate anticipatory guidance given.

Preventive:
Child: Growth discussed . Development discussed . Nutrition/Vitamins . Dental care . School readiness . Exercise . Chores/rules . Lead risk assessed .

Follow Up: well child in 1 yr,flu shot in the winter

Provider: Jessica L. Ruiz FNPC
Patient: K D **DOB:** **Date:** 09/19/2018

Electronically signed by Isabel Cervantes MA on 01/25/2019 at 12:05 PM MST
Sign off status: Completed